East End Health Plan

Student Status Certification for Dependents

TO BE COMPLETED BY COLLEGE:

_____, _____is enrolled as a
Name of Dependent Student ***Social Security #***

full-time student at _____
Name of Accredited Learning Institute

for the _____ school semester.
Date / Season of Semester

Anticipated Date of Graduation: _____
Note: Student must be enrolled for at least 12 credits per semester to be considered a full-time student.

_____
Signature of School Official

_____
Title of School Official

_____ _____
Date **Official School Seal**

TO BE COMPLETED BY PARENT:

Parent/Guardian Name (*Please Print*) _____

Signature of Parent/Guardian_____

Parent/Guardian Social Security Number _____

Effective Date of Student's Enrollment _____

Failure to complete and return this form to your School District's Health Plan Coordinator within 30 days of date on attached letter will result in termination of coverage for this dependent without any further notification from the East End Health Plan.

Mail Completed Form To: Your School District's Health Plan Coordinator